PRINTED: 04/11/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445278	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEWOOD NURSING CENTER, INC	332 RIVER ROAD DECATUR, TN 37322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #27818 were completed at Brookwood Nursing Center on April 4-7, 2011. No deficiencies related to complaint investigation #27818 were cited under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	This plan of correction is our credible allegation of compliance. "Preparation and/or execution of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law."	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to provide appropriate incontinent care for one resident (#12) of twenty residents reviewed. The findings included: Resident #12 was readmitted to the facility on July 16, 2009, with diagnoses including Atrial Fibrillation, Adult Failure to Thrive, Diabetes, and Hypertension. Observation on April 4, 2011, at 8:45 a.m., in the	F 315	F-315- No Catheter, prevent UTI, restore bladder What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: 1. CNA #1 received disciplinary action on 4/8/11 for improper peri-care, hand washing and usage of gloves regarding resident #12. 2. CNA reviewed policy(s) for peri -care, hand washing, and proper changing of gloves on 4/8/11. 3. CNA demonstrated compliance with per care, handing washing and changing of gloves through	4/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/22/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 315	Continued From page 1 resident's room, revealed Certified Nursing Assistant (CNA) #1 providing incontinence care to the resident. Continued observation revealed the resident had been incontinent of stool. Continued observation revealed CNA #1 donned gloves, positioned the resident on the left side, and proceeded to clean the buttocks. CNA #1 then rolled the resident onto the back and proceeded to clean the stool from the pubic area. CNA #1 adjusted the linen on the resident, removed gloves, and retrieved additional wash cloths. CNA #1 donned gloves and proceeded to finish cleaning the pubic area. Continued observation revealed after cleaning the pubic area, CNA #1, without changing the gloves, placed a brief, pants, shirt, and shoes on the resident. Review of the facility's policy Perineal Care revealed "...wash the pubic area first...make sure to always wipe from front to back to prevent spreading infection." Review of the facility Hand washing policy revealed "...5. After contact with contaminated objects...7. Before and after using protective gloves..." Interview with CNA #1 on April 4, 2011, at 12:45 p.m., in the hallway, confirmed CNA #1 had failed to follow the policy for providing appropriate incontinence care, and had failed to remove gloves or disinfected hands after providing care prior to dressing the resident.	F 315	skills check-off on 4/8/11. How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken: 1. Any resident has the potential to be affected by the same alleged deficient practice(s). 2. Nursing staff re-educated on 4/8/11 regarding peri-care, hand washing and changing gloves. 3. Skills check off performed by CNA 's on peri-care, hand washing, and changing gloves by 4/22/11. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur: 1. Annual skills check off to include peri-care, hand washing and changing gloves by nursing administration or designee first on completed 4/25/11. 2. Random skills checks in the above areas twice monthly until	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/27/11

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, observation, and interview, the facility failed to ensure safety devices were in place to prevent falls for one resident (#13) and failed to develop interventions to prevent falls for two (#9,#11) of twenty residents reviewed resulting in harm from a scalp laceration requring six staples for resident #9. The findings included: Resident #9 was admitted to the facility on January 13, 2011, with diagnoses including Acute Monocytic Leukemia (End Stage), Metastatic Diagnosis, General Weakness, Fatigue, Parkinson's Disease, and Glaucoma. Medical record review of the Minimum Data Set (MDS) dated January 17, 2011, revealed the resident had short term memory deficit and the resident's cognition status was moderately impaired-decisions poor; cues/supervision required. Further review revealed the resident required total dependence for bed mobility and transfers. Medical record review of the Admission Care Plan dated January 13, 2011, revealed "...Falls/Safety Risk/Elopement Risk...Keep call bell in reach...Encourage/Instruct use of call light...Instruct resident on safety measures, repeat prn (as needed)..."	F 323	100% compliance is achieved and maintained for 3 months begun 419.11. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: 1. Results of annual and random skills check off in the areas of peri-care, hand washing and changing of gloves will be reviewed by QA beginning at May 62011 QA meeting. F323- Free of accident hazards/ supervision/devices What corrective action(s) will be accomplished for those residents found to have been affective by the alleged deficient practices: 1. Resident #13 was reviewed by IDT 4/8/11. 2. Care Plan and Medical Record updated with interventions at time of review and safety devices found to be in place and appropriate. 3. Resident #9 and #11 reviewed by IDT to ensure that adequate	

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F 323	Continued From page 3 Medical record review of a Fall Risk Assessment dated January 13, 2011, revealed "...Total Score 16...Total score of 10 or above represents HIGH RISK..." Medical record review of a nurse's note dated January 15, 2011, at 12:00 a.m. (midnight) revealed "...Found sitting in floor feet extended...no c/o (complaints of) pain or discomfort...RR (siderails) in up position shortly before incident but had either fallen or resident had released...Sm (small) abrasion on R (right) knee 1 cm (centimeter) with dime size blood spot on sheet...no redness noted on buttocks..." Review of the facility investigation dated January 15, 2011, at 12 M (midnight) revealed "...Past Interventions...Encourage use of call light for assistance...Recommendations/New Interventions...Notify family and MD (Medical Doctor-notfied on January 15, 2011, at 2:00 a.m.)...Maintenance to assess siderail..." Review of a Equipment Data and Repair Log (maintenance) dated January 17, 2011, revealed "...Checked out side rails on bed...ok...resident could move release her self..." Medical record review of a nurse's note dated January 15, 2011, (no time), "...Resident got up OOB (out of bed), Both siderails up fell to floor hittin (hitting) back of head. Gash noted to back of head. Pulled foley cath out also..." Continued medical record review revealed a Physician's Telephone Order dated January 15, 2011, at 11:30 a.m., revealed "...send resident to (name) hospital ER (emergency room) for tx (treatment) and eval (evaluation)..."	F 323	and appropriate fall preventions in place 4/8/11. How will you identify other resident having the potential to be affected by the same alleged deficient practice(s) and what corrective actions will be taken: 1. Any resident has the potential to be affected by the same alleged deficient practice(s). 2. 100% audit of all charts specifying the residents of a fall risk of 10 or above to be completed 4/25/11. 3. Any resident found to have a fall score of 10 or above will be reviewed by the IDT for appropriate interventions and safety devices beginning 4/11/11. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur: 1. Fall risk assessment of resident reviewed upon admission/readmission,	

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F 323	Continued From page 4 Medical record review of a hospital emergency department record dated January 15, 2011, revealed "...Pt. (patient) diagnosis 3 cm (centimeter) scalp laceration, head injury..." Medical record review of hospital physician's orders dated January 15, 2011, at 4:05 p.m., revealed "...Return to N.H. (Nursing Home)...Continue Previous Orders ...Neuro (neurological) checks (evaluations) q (every) 2 hours x 24...Remove scalp staples 1 wk (week)..." Continued medical record review revealed the facility began neurological checks on January 15, 2011, at 5:30 p.m. and ended on January 16, 2011, at 5:30 p.m. Review of a facility investigation dated January 15, 2011, at 11:30 a.m., revealed "...found lying in floor at the end of bed...hematoma and laceration...climbed to end of bed pulling out foley cath (catheter) and falling to floor on to back..." Continued review of the facility investigation revealed "...Recommendations/New Interventions...Tab alarm in bed..." Observation on April 5, 2011, at 7:15 a.m., revealed the resident lying on a low bed, a safety tab alarm clipped to the resident's gown, mattress in a concave-shape with bilateral mobile side rails at the head of the bed, and bilateral safety mats on the floor beside the resident's bed. Interview on April 5, 2011, at 9:45 a.m., with the Director of Nursing (DON), the Assistant DON, and the Restorative Nurse, in the DON's office confirmed the safety tab alarm was not put in place until after the initial fall on January 15, 2011, at 12 midnight and further confirmed the safety tab alarm was not put in place until after the second fall on January 15, 2011, at 11:30	F 323	quarterly, and PRN with change in condition. Ensure appropriate fall prevention and safety devices in place for resident determined to be at risk beginning 4/11/11. 2. MDS/deginee will report any resident with a fall risk of 10 or more beginning 4/25/11. 3. Occurrence report reviewed and revised on 4/8/11. 4. Licensed nurses in-serviced on immediate/appropriate interventions to be put in place on any incident occurring on their shift on 4/8/11. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: 1. Review of incident reports in Morning meeting by IDT 4/8/11. 2. Daily safety devices monitored by restorative for proper placement and functioning beginning 4/8/11.. 3. MDS/dessgnee to review and report to OA findings of fall risk assessments interventions	

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F 323	Continued From page 5 a.m. Continued interview confirmed the second fall from the bed required a transfer to the hospital emergency department for treatment of a scalp laceration requiring six staples resulting in harm for the resident. Resident #13 was admitted to the facility on April 19, 2008, with diagnoses including Degenerative Joint Disease, Osteoporosis, Glaucoma, Cerebral Vascular Accident and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated September 15, 2010, revealed the resident had short term memory impairment, modified difficulty in cognitive skills for daily decision making, was independent with transfers and walking in the room. Medical record review of a nurse's note dated November 9, 2010, at 5:50 a.m., revealed "...woke up (resident's name)...could...shower... (resident name) sit up very quickly...turned on (resident's) light got up and walked...turned around to (too) fast and fell on the floor..." Continued record review revealed the resident had no injuries. Review of the facility investigation dated November 10, 2010, revealed "...past interventions...non slip shoes/slippers..." Medical record review of a nurse's note dated January 21, 2011, at 1:15 a.m., revealed "...Res (resident) was found lying flat on (resident's) back on floor in room...'slid off the bed,' then laughed...'is not hurt.'	F 323	beginning 4/25/11. F328-Treatments care for special needs What corrective action(s) will be accomplished for those residents found to have been affective by the alleged deficient practices: 1. Resident #21 son received signed education on oral and tracheal suctioning. Son verbalized and demonstrated understanding of procedure on 4/14/11. 2. Nursing staff reeducated and disciplinary action taken related to lack of documentation and/or actual suctioning oby 4/15/11. How will you identify other resident having the potential to be affected by the same alleged deficient practice(s) and what corrective actions will be taken: 1. Any resident has the potential to be affected by the same alleged deficient practice(s). 2. 100% audit of all residents to determine which currently have	

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F 323	Continued From page 6 Review of the facility investigation dated January 21, 2011, (no time), revealed "...Resident attempted to go to bathroom...slipped on floor and slid to floor...Resident was wearing regular socks...Recommendatons/New Interventions...assure non-skid socks are on when in bed..." Observation on April 5, 2011, at 4:25 p.m., in resident's room, revealed the resident seated in a wheelchair wearing tennis shoes. Interview on April 7, 2011, at 11:30 a.m., with the Resident Assessment Coordinator, at the nurse's station, confirmed the facility failed to ensure the non-skid footwear was in place at the time of the November 9, 2011, at 5:50 a.m., and January 21, 2011, at 1:15 a.m., falls. Resident #11 was admitted to the facility on August 8, 2003, and readmitted on August 6, 2008, with diagnoses including Chronic Organic Brain Psychosis, General Osteoarthritis, Hypertension, and Depressive Disorder. Medical record review of the Fall Risk Assessment revealed "...Total Score...A resident who scores a 10 or higher is at risk..." Continued review of the Fall Risk Assessments dated October 29, 2010 (total score 12), and January 27, 2011 (total score 20), revealed the resident was at high risk for falls. Medical record review of a Physician's Telephone Order dated November 24, 2010, revealed "safety alarm to bed & (and) chair." Medical record review of the resident's current Care Plan revealed "safety alarm to bed & chair."	F 323	special services: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileotomy care; tracheostomy care, respiratory care; foot care; and prosthesis completed 4/11/11. 3. 100% of all current residents receiving special services or their responsible parties reviewed for knowledge deficit pertaining to practices requiring a licensed professional. To be completed by 4.25.11 What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur: 1. Education sheet created 4/11/11. 1. Education needs of residents receiving special services and or their responsible parties will be addressed PRN by appropriate discipline upon admission and on going with new orders/significant change beginning 4.11.11. 2. Reeducated licensed nurses and #21 son reeducated on oral	

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F 323	Continued From page 7 Review of a facility investigation revealed the resident had four non-injurious falls from March 11, 2010, through November 24, 2010. Observation on April 4, 2011, at 9:35 a.m., revealed the resident lying on the bed with the safety alarm lying on top of the bed, near the resident's head. Continued observation revealed the safety alarm clip was not attached to the resident. Interview on April 4, 2011, at 9:40 a.m., with Licensed Practical Nurse (LPN) #1 in the resident's room confirmed the facility failed to ensure the safety alarm clip was attached to the resident.	F 323	tracheal suctioning completed 4/14/11. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: 1. Proficiency of knowledge of licensed nurses o r family wishing to provide proper treatment/ care for special needs residents will be measured by evaluation, verbalization and demonstration . DON or designee will share results at QA. F441-Infection control, prevent spread, linens What corrective action(s) will be accomplished for those residents found to have been affective by the alleged deficient practices: 1. Cups removed from resident #21 room on 4/8/11.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide family	F 328		4/22/11

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F 328	Continued From page 8 education to ensure proper tracheal and oral suctioning was provided for one resident (#21) of twenty residents reviewed. The findings included: Resident #21 was admitted to the facility on September 1, 2010, with diagnoses including Laryngeal Cancer, Tracheostomy, Dysphagia, and Chronic Obstructive Pulmonary Disease. Medical record review of a Physician's Telephone Order dated January 20, 2011, revealed "...deep suction patient at least 2-3 x per shift (deep suction at least two to three times per shift)..." Continued review of a Physician's Telephone Order dated March 15, 2011, revealed "...do not deep suction resident-suction trach PRN for increased secretions..." Observation in the resident's room on April 6, 2011, at 3:50 p.m., revealed a family member suctioning the resident's mouth with a catheter suction tip. Interview with the family member at this time revealed family members have suctioned the resident's trach. Interview with the Director of Nursing (DON) in the Social Service Director's Office on April 7, 2011, at 9:40 a.m., confirmed the facility failed to provide oral and/or tracheal suctioning education to the family.	F 328	2. Self administration assessment reevaluated with resident #21 son related to infection control issues on 4/20/11. 3. Resident #21 was determined by IDT and son to D/C self administration of tube feed related to inability to maintain infection control procedures on 4/20/11. How will you identify other resident having the potential to be affected by the same alleged deficient practice(s) and what corrective actions will be taken: 1. Infection control rounds performed in resident rooms on 4/8/11. Compliance achieved at time of inspection. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur: 1. DON/ ADON reviewed Information placed in admission packet concerning proper infection control and assured	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		4/29/11

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F 441	Continued From page 9 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 441	that all incoming residents/responsible parties would be properly educated on proper infection control procedures/ practices on 4/20/11. 2. Reeducate staff with visual identification of infection control issues completed 4/20/11. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: 1. Infection control rounds weekly x3 weeks, q month until compliance is achieved beginning 4/8/11. 2. Random audits after compliance achieved to maintain. 3. Staff to verbalize understanding of proper infection control practices. 4. Results reported in QA by Infection Control nurse or designee beginning at the May6, 2011 meeting.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445278	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEWOOD NURSING CENTER, INC	332 RIVER ROAD DECATUR, TN 37322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 and interview, the facility failed to ensure a sanitary environment to prevent the development and transmission of disease and infection for one resident (#21) with a feeding tube, of twenty residents reviewed. The findings included: Resident #21 was admitted to the facility on September 1, 2010, with diagnoses including Laryngeal cancer, Dysphagia, and Chronic Obstructive Pulmonary Disease. Medical record review of the Physician's Recapitulation Orders dated April 1, through April 30, 2011, revealed "...240cc (cubic centimeters) 2 Cal HN (a high-calorie liquid food) per PEG (a tube passed into the stomach through the abdominal wall to provide a means of feeding, also known as enteral feeding, when oral intake is not adequate or possible) while awake...7:00AM, 11:00AM, 3:00PM, 7:00PM..." Observation in the resident's room on April 7, 2011, at 8:45 a.m., revealed three, clear-plastic measuring cups, one-cup size each, placed upside down on a wet paper towel, inside a clear, plastic container on the resident's overbed table. Continued observation revealed two of the measuring cups contained a dried, thick, whitish-substance (in one cup on the inside bottom and a second cup on the outside rim of the cup's top). Interview with the Director of Nursing (DON) in the Social Service Director's Office on April 7, 2011, at 9:30 a.m., revealed the measuring cups in the resident's room are used for the 2-Cal HN formula during the resident's enteral feedings.	F 441		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 11 Further interview revealed the family takes the measuring cups home and washes them periodically. Continued interview confirmed the facility does not wash the measuring cups and the facility had failed to ensure a sanitary environment for the resident.	F 441		